FINDLAY FAMILY CHIROPRACTIC CLINIC
2303 N. MAIN ST. FINDLAY, OHIO 45840
PH: 419-424-9922 FAX 419--424-3256

ACCIDENT & INJURY PAIN CENTER
602 W. SYLVANIA AVE. TOLEDO, OH
PH:419-478-8600 FAX 419-478-1288

CONFIDENTIAL PATIENT INFORMATION

NAME (last)_____(first)_____(MI)_____

ADDRESS_____
(Street) (City) (State) (Zip)

HOME PHONE# _____**WORK#**_____**CELL#**_____

BIRTH DATE_____ **EMAIL**_____

HEIGHT_____ **WEIGHT**_____ **DO YOU USE TOBACC0?**_____

MARITAL STATUS: S M OTHER **SS#**_____

HEALTH INS: BCBS MED MUTUAL AETNA MEDICAID OTHER_____

POLICY HOLDER:_____ **POLICY HOLDER DOB:**_____

IS THIS :
A WORKERS' COMP CLAIM____ **AUTO POLICY CLAIM**____ **PERSONALINJURY**_____

EMERGENCY CONTACT PERSON NAME_____ **PH#**_____

NAME OF PRIMARY CARE PHYSICIAN_____

LIST ALL SURGERIES
TYPE_____ WHEN_____
TYPE_____ WHEN_____
TYPE_____ WHEN_____

ACCIDENTS OR INJURIES IN THE LAST 5 YEARS
TYPE_____ WHEN_____
TYPE_____ WHEN_____

LIST ALL MEDICATIONS
TYPE_____ WHEN_____
TYPE_____ WHEN_____
TYPE_____ WHEN_____

REASON YOU ARE VISITING US TODAY_____

WHEN DID THIS BEGIN?_____HAS THIS OCCURED BEFORE? Y N WHEN_____

DID PROBLEM BEGIN ( )gradually ( ) immediately after an event Explain_____

DESCRIBE YOUR PAIN (you may check more than one) ( )Sharp/stabbing ( )Dull/achy ( )Numbness ( ) Weakness ( ) Shooting ( ) Throbbing
HOW OFTEN ARE COMPLAINTS PRESENT? ( ) Constant ( ) Hours per day ( ) Weeks ( ) Months

SINCE YOUR PROBLEM BEGAN, IS THE PAIN: ( ) Increasing ( ) Decreasing ( ) Not Changing

HAVE YOU SEEN ANOTHER PHYSCIAN FOR THIS CONDITION_____WHO?_____

WERE ANY OF THESE TESTS PERFORMED? XRAYS MRI CT SCAN EMG OTHER_____

DO YOU HAVE ANY
VOMITING, NAUSEA, FEVER, CHILLS, UNEXPLAINED WEIGHT LOSS/GAIN?_____

HAVE YOU EVER BROKEN RIBS OR HAD SERIOUS SPINAL INJURIES?_____
(IF YES PLEASE EXPLAIN TO DR UPON EXAMINATION)

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE_____ IF SO WHEN_____

WOMEN: IS THERE ANY REASON TO BELIEVE THAT YOU MAY BE PREGNANT?_____

IN THE EVENT OF NEED TO COMMUNICATE HEALTHCARE INFO TO WHOM MAY WE DO SO? NO ONE:_____
NAME:_____ RELATIONSHIP_____
NAME:_____ RELATIONSHIP_____
MAY WE LEAVE VOICEMAILS IN REGARD TO YOUR HEALTHCARE _____

INFORMED CONSENT

A patient, incoming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient suspecptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-dupicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Findlay Family Chiropractic Clinic, I am authorizing them to proceed with type of treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

ACKNOWLEDGEMENT: I have read and fully understand the above statements. I have reviewed the privacy practices (HIPPA) and will be given a copy upon request.

PRINT NAME_____ SIGNATURE_____ DATE_____

Please check any other the health problems/conditions that you HAVE or HAVE HAD in the past:

Headaches_____ Dizziness _____
Neck Pain ____ Pins/Needles in arms/hands ____ Pain b/w the shoulder blades _____
Low Back Pain _____ Pain in legs and feet _____ Pain in joints _____
Diabetic problems _____ Heart Problems _____ High Blood Pressure _____
Breathing problems _____ Asthma _____
Sinus problems _____ Allergies _____
Eye problems _____ Ear problems _____
Indigestion _____ Stomach problems _____
Skin problems _____ Gall Bladder problems _____ Thyroid problems _____
Constipation _____ Bladder problems _____ Bowel problems _____
Liver problems _____Kidney problems _____ Menstrual problems _____
Weight problems _____ Fatigue _____ Sleeping problems _____

TERMS OF ACCEPTANCE

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze, and correct vertebral subluxations. The purpose being to improve joint mechanics and to restore the innate healing mechanisms of the body via a nervous system free of irritation/interference.

*_____ INITIALS

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic. Not limited to but including deductible, co-payment, and any services rejected by my insurance company.

Financial Policies:

- We will try our best to inform you of your insurance benefits, however we cannot be held responsible for what your insurance company tells us over the phone. Your EOB(Explanation Of Benefits) is what we have to legally go by.

*_____ INITIALS

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as original

*_____ INITIALS

RELEASE OF INFORMATION

I authorize this clinic to release any patient information from my case to any insurance company, adjuster, and/or attorney involved in my case; and hereby release this clinic of any consequence thereof.

*_____ INITIALS

MISSED APPOINTMENT POLICY

Findlay Family Chiropractic Clinic reserves the right to bill any patient for a missed appointment with no advance notice of cancellation or reschedule.

*_____ INITIALS

SIGNATURE_____ DATE_____.